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ABSTRACT

In an effort to conform to the Massachusetts Executive Office of Elder Affairs (EOEA) staff development requirement regarding elder abuse, a learning module was developed. It was designed to be administered to an individual caregiver for the purpose of self-study or to small groups of caregivers using the lecture-discussion format. Following the seven-page report is the learning module for resident assistants, entitled Preventing and Reporting Resident Abuse. Introductory materials include a list of learning objectives; introduction; and research on prevalence of elder abuse. Informative material is provided on types of resident abuse, such as physical abuse, psychological or emotional abuse, neglect, self-neglect, and financial exploitation or misuse; causes of resident abuse; and things one can do about abuse. Appendixes include a 14-item bibliography, list of 11 web sites and materials available online; post-test; and sample resident abuse investigation report form. (YLB)

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PREVENTING AND REPORTING RESIDENT ABUSE IN ASSISTED LIVING: A LEARNING MODULE FOR RESIDENT ASSISTANTS

By

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SENIOR LIVING SERVICES: PROVIDING ASSISTED LIVING ACROSS THE NATION

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Abstract

The buzzwords standing for the concept "aging in place" refers to assisted living care. There is an attitude in assisted living that the resident has choices. The assisted living population is not a colossal group. There are no uniform federal rules for assisted living facilities. Staff can tailor programs to the needs of the individual residents. The Commonwealth Executive Office of Elder Affairs (EOEA) regulates assisted living communities in Massachusetts. The final regulations (651 CMR 12.00 Final Regulations) include staff training requirements. There were 241,000 reports of elder abuse in 1994, a 106 percent increase from a 1986 national study (National Center for Elder Abuse, 1996). Missing in the required training hours is diversity education and its impact on assisted living residents. A learning module, including a post-test, was designed and presented to assisted living caregivers. A suggestion for other trainers facing the challenge of developing resident abuse prevention and reporting programs is to include a curriculum thread on resident-to-caregiver abuse, as well as ethnicity and its effect on resident abuse.

INTRODUCTION

Elders use of long-term care facilities is no longer limited to the traditional nursing facility in our country today. Assisted living is a trend fueled by a desire for a residential solution for those who do not need 24-hour medical or nursing care but who do need help with activities of daily living (ADLs). The buzzwords standing for the concept "aging in place" refers to assisted living care. There is an attitude in assisted living that the resident has choices. Fisher (1997:53) writes, "the growing 'young' retirement population is more affluent than previous generations and likes the philosophy of promoting choice and independence found in assisted living facilities."

There are no benchmarks that could help the financial community understand the assisted living industry. Currently eighty percent of the owners developing assisted living residences are for-profit companies (Cinelli, 1996). The assisted living population is not a monolithic group. The average length of stay falls between one year, three, and a half years. Despite the fact that life, safety, and building codes present challenges, overall, the industry's growth outlook remains solid (Fisher, 1997).

There are no uniform federal rules for assisted living facilities. The process for providing guidelines and standards falls to the states. Staff can tailor programs to the needs of the individual residents. Care plans in most states must be developed within the first forty-eight hours after initial screening, though some states allow ten to thirty days to develop the plan of care. Assisted living care plans may include laundry needs, housekeeping arrangements, dining provisions, emergency systems, medication management, and ADL. The requirements for developing a care plan and for the components of the care plan are vague, at best, and vary from state to state (Coats, 1996).

The Commonwealth Executive Office of Elder Affairs (EOEA) regulates assisted living communities in Massachusetts. Besides being responsible for the application and certification procedures, the EOEA sets the standards for resident care in assisted living residences. The final regulations (651 CMR 12.00 Final Regulations) include staff training requirements. Prior to active employment, all staff and contracted providers having direct contact with residents, and all food service personnel, must receive a six-hour orientation which includes the following topics: dementia/cognitive impairment, the aging process, resident Bill of Rights and elder abuse, neglect and financial

exploitation. A minimum of six hours per year of ongoing education and training is required for all employees and providers, aimed at reinforcing the initial training.

Published in the August 13 issue of *Time Magazine*, author Andrew Goldstein compares and contrasts assisted living residences with nursing homes in a negative story titled "Better Than a Nursing Home?" The author details incidents of inadequate care and staff training and profiles problems that arose at a mid-western facility. Inadequate resident care examples included in the article focused on residents not receiving medications and not receiving proper incontinence care, which resulted in skin breakdown. The article also examines the origin of assisted living and is critical of the tremendous growth of the profession and lack of federal oversight. The National Center for Assisted Living (NCAL) staff did talk to the reporter at length prior to publication of the *Time* report, about a host of issues, including that assisted living has a high customer satisfaction level - a point the writer makes in his report.

The U.S. Department of Health and Human Services issued its third in a series of reports about assisted living, titled "High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a Nation Survey." All data and conclusions are based on information obtained during site visits to 300 facilities that were part of the original sample of several thousand facilities. The visits included interviews with administrators, staff, residents, and family members, as well as walk-through evaluations of the facility environment. One major finding is that while residents were critical of the lack of staff training and high staff turnover, they did feel they were treated with respect, affection, and dignity.

Problem

There were 241,000 reports of elder abuse in 1994, a 106 percent increase from a 1986 national study (National Center for Elder Abuse, 1996). Around this same time, the U.S. House of Representatives Select Committee on Aging found that five to ten percent of elders may be victims of moderate to severe physical abuse, which is far less likely to be reported than other types of abuse. The elderly with disabilities are unlikely to complain about abuse, neglect or victimization under the fear they will lose whatever support, even abusive, they have and that their complaints will trigger reprisals. The Center also found that female victims constituted sixty-two percent of elder

abuse cases, and more than twelve percent involved financial or material exploitation.

The literature addressing elder abuse strongly suggests that many people that were not nice when they were young are even less nice when they get old. An elder's children and caregivers may be mean spirited or cold people as well. Putting up with mean-spirited elders tends to shorten the fuses of many caregivers, particularly when they are not getting recognition for their efforts. The World Medical Association (1990) adopted some general principles relating to the abuse of the elderly, which included care-givers responsibility to help prevent elder abuse and elder's rights to the same care, welfare and respect as other human beings.

Abuse of the elderly can be manifested in a variety of ways, such as physical, psychological, and financial and/or material, medical abuse or self-neglect. Variations in the definition of elder abuse present difficulties in comparing findings on the nature and causes of the problem. A number of hypotheses have been proposed on the etiology of elder abuse, including the following: dependency on others to provide services, lack of close family ties, family violence, lack of financial resources, psychopathology of the abuser, lack of community support and institutional factors such as low pay, under-qualified and over-worked staff, and poor working conditions. The literature suggests that staff development and training can help to counter pessimistic attitudes of caretakers, resulting in neglect of the elderly.

Background and Significance

Since its doors opened in September of 1999, Senior Living Services' metro-south Boston residence, one of 161 such residences owned by the company, has provided assisted living and special care to well over a hundred elders. Approximately one-third of the residents has a diagnosis of dementia, mostly of the Alzheimer's type. All services provided at the metro-south Boston residence are private pay. The line staff encompasses a diversity of nationalities and ethnic backgrounds, including Haitian, Puerto Rican, Portuguese and African American.

The six hours of orientation inservices and annual ongoing training required of assisted living staff by the EOEA in Massachusetts is contact hours, not continuous education units (CEUs). As long as the content area is covered in some fashion, oftentimes via computer tutorial without human interaction or

opportunity for discussion, the training is compliant with EOEA regulations. Missing in the required training hours is diversity education and its impact on assisted living residents. Sensitivity training is required, but only in the sense that the needs of the elderly are considered. Training regarding the impact culturally diverse caregivers have on residents is glaringly absent from the EOEA staff development regulations. Without consideration of this vital variable, sensitivity training and knowledge of the aging process is inadequate to thwart psychological or emotional abuse of elders. What a Caucasian middle to upper class resident perceives as harsh or abusive behavior may be significantly different from what the caregiver perceives as abuse and vice versa.

In an effort to conform to the EOEA staff development requirement vis-à-vis elder abuse, a learning module was developed. It was designed to be administered to an individual caregiver for the purpose of self-study, or to small groups of caregivers using the lecture-discussion format. Past history attests to the difficulty in offering group training on the night shift, therefore, it was believed the self-study module, with a post-test graded by the assisted living manager, would improve compliance. To date, approximately seventy-five percent of the resident assistants in the community have successfully completed the training. All but a few aides on the night shift participated in small group discussion after being allocated ample time to read the module and to ask for clarification of the information. The assisted living manager facilitated the exercise, with the knowledge that English was the second language for the majority of caregivers.

The assisted living manager determined that resident assistants working in the community were not comfortable with the subject matter. They did, however, actively participate in a discussion about resident abuse of caregivers. They cited several examples of times when residents called them racist and/or sexist names. The trainer provided staff with the community's "harassment" policy and procedure, along with a confidential telephone number where calls can be made to a corporate-level human resources officer who investigates abuse. Once staff realized they were protected from physical, psychological or emotional, sexual, and financial abuse, they were more receptive to entertain the notion of caregiver to resident abuse. Seemingly, staff were surprised, and somewhat naïve, relative to how their ethnicity affected residents. They were unaware that residents sometimes complained about caregivers, claiming they were sometimes hostile, loud and bossy.

The unanticipated outcome of the resident abuse inservice was the cathartic counseling session that surfaced, as a caregiver need. A few resident assistants were reluctant to discuss resident abuse and the fact they had personally been abused by residents, however, they made comments to the assisted living manager after the session. A suggestion for other trainers facing the challenge of developing resident abuse prevention and reporting programs is to include a curriculum thread on resident to caregiver abuse, as well as ethnicity and resident abuse. A copy of the learning module follows in its entirety.

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PREVENTING AND REPORTING RESIDENT ABUSE:
A Learning Module for Resident Assistants - One Contact Hour

Learning Objectives:

1. **Identify the types of resident abuse**
2. **Identify the signs and symptoms of resident abuse**
3. **Describe how to report suspected resident abuse**
4. **Review community's resident abuse investigation report form**

BRIGHTON GARDENS BY MARRIOTT: DEDHAM, MA
Cole McKinnon, Assisted Living Manager
September, 2001

TABLE OF CONTENTS

Page

LEARNING OBJECTIVES *1*

INTRODUCTION *3*

RESEARCH *3*

TYPES OF RESIDENT ABUSE *3*

Physical Abuse *4*

Psychological or Emotional Abuse *4*

Neglect *4*

Self-Neglect *5*

Financial Exploitation or Misuse *5*

CAUSES OF RESIDENT ABUSE *5*

THINGS YOU CAN DO ABOUT ABUSE *6*

CONCLUSION *6*

BIBLIOGRAPHY *7*

POST-TEST *9*

APPENDIX:

Resident Abuse Investigation Report Form

INTRODUCTION

People are living longer in society today. Many elders require care in assisted living communities and nursing homes because they cannot protect or care for themselves. Neglect is the most common form of elder abuse. Frequently the elder person's family members or caregivers are the abusers! Abuse comes in many forms, and it is our responsibility to understand it, report it, and prevent it.

RESEARCH

Approximately 44 million elders in this country are over the age of 60. With this number of older Americans comes a growing problem...elder abuse. It is estimated that 1.5 million elders or 1 in 25 elders are abused each year.

Elder abuse can happen to anyone, although those with physical or mental disability are at greatest risk. Females are abused more often than males. Elders, 80 years and older, are abused two to three times more often. Elders with dementia, less family support, multiple medical problems, and in need of more assistance with activities of daily living (ADLs) are also at a greater risk for abuse. Sometimes elders are abused by their spouses or children, but mostly they are abused by their caregivers, in their homes or in resident care communities like ours.

Elders are sometimes victims of self-neglect, another type of abuse. These people are usually depressed, confused, or extremely frail. There are many types of elder abuse.

TYPES OF RESIDENT ABUSE

The types of elder abuse include:

- **physical abuse, including sexual abuse**
- **psychological or emotional abuse**
- **neglect (this is the most common type)**
- **self-neglect**
- **financial exploitation or misuse**

Physical Abuse

Signs of physical abuse include:

- **cuts, skin tears, puncture wounds**
- **bruises, especially on upper arms or on the trunk (may be a combination of old and new bruises)**
- **burns**
- **poor hygiene**
- **skin deterioration, for example, bed sores**
- **falls**
- **absence of hair and/or bleeding under the scalp**

Psychological or Emotional Abuse

Signs and symptoms of psychological or emotional abuse include:

- **fear in the presence of caregiver or caregivers**
- **caregiver speaks for the resident**
- **denial of the abuse**
- **paranoia**
- **withdrawn or passive behavior**
- **agitation**
- **looking at the caregiver before speaking**
- **expressions of anger or resignation (an "I give up" kind of look)**

Neglect

Signs and symptoms of neglect include:

- **poor hygiene (if you do not assist resident with peri-care, showering, or hair/nail, care and it is supposed to be provided by you!)**
- **rashes, sores, or lice**
- **pressure sores or contractures**
- **glasses, dentures, hearing aides, and walking devices in poor repair or missing**
- **malnourishment or weight loss**
- **dehydration (lack of fluids)**

- **an untreated medical condition**
- **any indication that the resident was left unsafe or alone for long periods of time**

Self-Neglect

Signs and symptoms of self-neglect include:

- **wandering**
- **no food or spoiled food in apartment**
- **medications not being taken or refused**
- **evidence of alcohol or drug abuse (sneaking pills)**
- **failure to pay bills**
- **animal infested apartment**
- **poor hygiene and/or sores and/or the smell of urine or feces**
- **inappropriate clothing for the weather or soiled clothing**

Financial Exploitation or Misuse

Indicators of financial misuse include:

- **unpaid rent**
- **lack of appropriate clothing and/or personal grooming items**
- **condition of the apartment**
- **an excessive number of items ordered from TV, catalogues, etc.**
- **unusual concern by caregiver regarding the amount of money spent on care of the elder or spent by the elder**
- **level of personal care, nutrition, medical care, clothing, and availability of transportation**

CAUSES OF RESIDENT ABUSE

The burden of responsibility on caregivers grows heavier as older people live longer, especially for those who require a great deal of help with activities of daily living. Personal problems, unemployment, and substance abuse can cause resident assistants and other caregivers to become frustrated and act aggressively toward residents.

Sometimes entire families and particular individuals respond to stress with violence. "Sometimes family members unintentionally engage in cruel behavior because they are overwhelmed" - Dr. Jim Mittlerger, a geriatrician. Caregivers are not exempt from this truth. Caring for an elderly person, especially in small living quarters or apartments, can bring about stressful situations. Working short-handed, working more than one job, being under-qualified, dealing with a lot of personal stress and many other factors contribute to resident abuse.

THINGS YOU CAN DO ABOUT ABUSE

Elder abuse is against the law. Unfortunately, victims of elder abuse are often scared to report offenders and are unwilling to ask for an investigation. They may fear that you or their loved one will abandon them. They may believe you will get revenge. They may experience feelings of shame that they were weak enough to allow abuse. Be sensitive to those feelings. Always report findings of abuse or suspicions of abuse to a supervisor/manager. You, the resident assistant, can create an environment where the abused resident feels safe to discuss his or her problems with you. Keeping residents SAFE should be the priority!

CONCLUSION

Abuse of the elderly is not limited to physical or mental abuse. It is also abuse when they are exploited or when they abuse themselves by self-neglect. Threats, insults, teasing, intimidation, harsh orders, and general lack of respect, for example calling an elder "dear" or "sweetheart" can demonstrate mental abuse. Physical abuse can be confinement, rough care, burns, beatings, sexual abuse, cuts, and bruises. Neglect is the failure to provide the care necessary to protect an elder from physical or emotional harm. This can be lack of food, proper room temperature, confinement, improper clothing or hygiene, or lack of medical care. When a caretaker improperly or unethically uses an elder's money or resources for personal gain, this is termed financial exploitation. Some examples of exploitation would include stealing personal items, accepting monetary tips, eating food intended for an elder, or convincing an elder to change the beneficiary of his or her will.

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POST-TEST

1. **It is estimated that the number of elders abused each year is:**

   a. **50,000**
   b. **750,000**
   c. **1,000,000**
   d. **1,500,000**

2. **Having under-qualified and overworked staff can lead to resident Abuse.**

   a. **True**
   b. **False**

3. **Abused residents may not report the abuse because they fear The caregiver may get even or seek revenge.**

   a. **True**
   b. **False**

4. **Resident abuse can include:**

   a. **harassment**
   b. **controlling the resident with drugs or restraints**
   c. **restricting preferences or rights**
   d. **all of the above**

5. **The most frequent abusers of elders living in resident care communities is:**

   a. **nurses**
   b. **nursing assistants**
   c. **housekeepers**
   d. **managers**

6. **Self-neglected residents are usually:**

   a. **isolated**
   b. **mentally ill**

c. alcoholics
d. physically disabled

7. Resident assistants should report suspected resident abuse to their supervisor or manager.

   a. True
   b. False

8. The priority in every case of resident abuse is to keep the resident safe.

   a. True
   b. False

9. Signs of the most common type of resident abuse can include:

   a. hearing-aide not worn
   b. rashes or sores
   c. showers not given
   d. all of the above

10. The most common type of resident abuse is:

    a. self-neglect
    b. neglect
    c. physical
    d. all of the above

11. A resident who has many bruises on the upper arms and trunk is <u>always</u> a victim of abuse.

    a. True
    b. False

12. Residents most likely to be victims of abuse are those with:

    a. few dependency needs
    b. few family ties
    c. A strong sense of family

SENIOR LIVING SERVICES

RESIDENT ABUSE INVESTIGATION REPORT FORM

Name of Resident: _____ Room No: _____

Age: _____ ❑ Male ❑ Female

Location of Incident: _____

Date Incident Occurred: _____

Date Incident Reported: _____

Incident Reported By: ❑ Resident ❑ Associate ❑ Family Member ❑ Other Resident ❑ Family Member

Name(s) of Individual(s) Reporting Incident: _____

_____

Relationship to Resident (e.g., daughter, son, spouse, visitor, associate, etc.): _____

Type of Alleged Abuse: ❑ Physical ❑ Sexual ❑ Verbal/Mental ❑ Theft ❑ Neglect
❑ Other: _____

Resident Injured: ❑ Yes (describe injuries) ❑ No

_____

_____

Injuries required medical attention: ❑ Yes (describe) ❑ No

_____

_____

Did the medical record review indicate any previous or unexplained injuries? ❑ Yes (describe) ❑ No

_____

_____

_____

Name(s) of witness(es) to the incident: _____

Name of person(s) accused: _____

Is the accused individual(s) a(n): ❑ Associate ❑ Family Member ❑ Visitor ❑ Resident
❑ Other: _____

Summary of interview with person(s) reporting the incident (use additional pages as necessary):

_____

_____

_____

_____

_____

Summary of interview with witness(es) (use additional pages as necessary):

Summary of interview with resident (use additional pages as necessary):

Summary of interview with resident's family members/visitors (use additional pages as necessary):

Summary of investigator's findings (use additional pages as necessary):

Summary of the outcome of the investigation and any corrective action (if appropriate) taken:

(Continue Summary on Following Page if Necessary)

(Outcome Summary Continued)

Results of findings and any corrective action taken reported to:

- ☐ Representative/Family Date: _____ Time: _____ By Whom: _____
- ☐ Ombudsman Date: _____ Time: _____ By Whom: _____
- ☐ State Licensing Agency Date: _____ Time: _____ By Whom: _____
- ☐ Law Enforcement Agencies Date: _____ Time: _____ By Whom: _____
- ☐ Nurse Aide Registry Date: _____ Time: _____ By Whom: _____
- ☐ Administrator Date: _____ Time: _____ By Whom: _____
- ☐ _____ Date: _____ Time: _____ By Whom: _____
- ☐ _____ Date: _____ Time: _____ By Whom: _____

Additional Comments:

Date: _____ Signature - Investigating Representative: _____

Date: _____ Signature - GM/Administrator: _____